ACTION REQUEST FORM FOR INSURANCE REVIEW

Return form by: _____

Mail to: Amber Star Insurance, 6525 Houston Street, Buena Park, CA 90620
Fax to: 714-908-0417 Phone: (714) 735-7110
Email to: amber@amberstarinsurance.com

Personal Contact Information

Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Best Time to Call: _____

eMail: _____ Tobacco User: (Yes/No) _____

New Medicare MBI #: _____ Part A and Part B Active: _____

How Would You Like Quote Returned to You: Phone Call: _____ eMail: _____ Mailed: _____

Current Medical Information

Preferred Physician: _____ Medical Group: _____

Hospital: _____ Current Med Supl Plan: _____

Pharmacy Name/Address: _____ Mail Order: (Yes___/No___)

Current HMO Plan: _____ Current RX Plan: _____

Special Needs: (ex. Diabetes Type 1) _____

My Medication Information

Current Medication **EXACT** Name off Rx bottle and Type (Ex: Tab, Capsule, Cream, Gel)	**Dosage** (Ex: 10 mg)	**Frequency** (Ex: 1x, 2x day or 90 per month)	**If Drug is Name *Brand* Is *Generic* OK** Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No

Client is responsible for providing correct Rx information and verifying it once quotes are created. All information will be kept confidential.

❖ **Estimates calculated by www.Medicare.gov and are subject to change without notice.**

INTERNAL USE ONLY: Received: _____ SOA Rcvd: _____ ACT: _____
Quote ID # / Password Date: _____ Quote Sent: _____